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ABSTRACT

This report was prepared for the Wisconsin State Legislative Council's Special Committee on Mental Health Issues. It summarizes legal issues and procedures relating to the admission, commitment, and treatment of the mentally ill in Wisconsin. Part I sets forth legal definitions of certain key mental health terms, including mental illness as it is defined generally and in relation to involuntary commitment, chronic mental illness, incompetence, and developmental disabilities. Part II describes legal concepts which provide the basis for the legal rights currently provided to the mentally ill. This section looks at constitutional rights concerned with liberty interest, least restrictive setting, procedural due process, humane conditions and minimally adequate treatment, refusal of treatment, and release. It also examines statutory rights related to conditions of confinement, periodic review of placement, and confidentiality. Part III provides a detailed description of the current standards and procedures which apply to obtaining voluntary and involuntary care and treatment for the mentally ill within the civil court system. Part IV provides a brief description of the current statutory procedures which apply to receiving mental health treatment within the criminal justice system. (NB)

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THE LEGAL FRAMEWORK FOR CARE AND TREATMENT OF THE MENTALLY ILL

STAFF BRIEF 86-7

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TABLE OF CONTENTS

	Page
INTRODUCTION	1
PART I - LEGAL DEFINITIONS	3
A. MENTAL ILLNESS	3
1. Generally	3
2. Involuntary Commitment	3
B. CHRONIC MENTAL ILLNESS	3
C. INCOMPETENT	4
D. DEVELOPMENTALLY DISABLED	4
PART II - LEGAL CONCEPTS	5
A. CONSTITUTIONAL RIGHTS	5
1. Liberty Interest	5
2. Least Restrictive Setting	8
3. Procedural Due Process	8
4. Humane Conditions and Minimally Adequate Treatment	9
5. Refusal of Treatment	10
6. Release	12
B. STATUTORY RIGHTS	13
1. Conditions of Confinement	13
2. Periodic Review of Placement	14
3. Confidentiality of Records	15
PART III - OBTAINING TREATMENT AND CARE FOR THE MENTALLY ILL: STANDARDS AND PROCEDURES	17
A. INVOLUNTARY COMMITMENT	17
1. Standards for Involuntary Commitment	17
2. Alternative Standards for Involuntary Commitment	20
3. Involuntary Civil Commitment Procedures	21
4. Commitment Periods; Extensions	25

TABLE OF CONTENTS (continued)

Page

B. TEMPORARY INPATIENT DETENTION 26

1. Emergency Detention 26
2. Temporary Admission Pending Appointment of a Guardian 26
3. Short-Term Admission of Minors 26

C. PROTECTIVE PLACEMENT 27

1. Standards for Protective Placement 27
2. Protective Placement Procedures 28

D. EMERGENCY PLACEMENT 30

E. PROTECTIVE SERVICES 30

F. EMERGENCY SERVICES 31

G. GUARDIANSHIP AND CONSERVATORSHIP 31

1. Guardianship 31
2. Conservatorship 33

H. VOLUNTARY ADMISSION OF ADULTS TO TREATMENT FACILITIES 33

I. VOLUNTARY ADMISSION OF MINORS TO TREATMENT FACILITIES 34

J. VOLUNTARY ADMISSION TO PROTECTIVE PLACEMENT FACILITIES 35

PART IV - COMMITMENTS ARISING OUT OF CRIMINAL PROCEEDINGS 37

A. INCOMPETENCY TO STAND TRIAL 37

1. Standard 37
2. Procedure 37

B. NOT GUILTY BY REASON OF MENTAL DISEASE OF DEFECT . . . 38

1. Standard 38
2. Procedure 39

C. CIVIL COMMITMENT OF A PRISON INMATE 39

Wisconsin Legislative Council Staff — Madison, Wisconsin

Special Committee on Mental Health Issues — July 16, 1986

STAFF BRIEF 86-7*

THE LEGAL FRAMEWORK FOR CARE AND TREATMENT OF THE MENTALLY ILL

INTRODUCTION

On February 20, 1986, the Legislative Council established the Special Committee on Mental Health Issues, pursuant to a December 20, 1985 letter to the Legislative Council from Senator Fred A. Risser. The Committee is directed to undertake a thorough examination of present mental health concerns, including a study of: (a) community and institutional programs and services for the mentally ill; (b) present civil commitment standards and alternatives thereto; and (c) services available to the mentally ill in prisons and jails.

This Staff Brief, summarizes legal issues and procedures relating to the admission, commitment and treatment of the mentally ill in Wisconsin.

PART I sets forth legal definitions of certain key mental health-related terms.

PART II describes legal concepts which provide the basis for the legal rights currently provided to the mentally ill.

PART III provides a detailed description of the current standards and procedures which apply to obtaining voluntary and involuntary care and treatment for the mentally ill within the civil court system.

PART IV provides a brief description of the current statutory procedures which apply to receiving mental health treatment within the criminal justice system.

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*This Staff Brief was prepared by Pam Russell, Staff Attorney, Legislative Council Staff.

PART I

LEGAL DEFINITIONS

This Part of the Staff Brief sets forth the legal meanings of certain mental health terms, as defined in the Wisconsin statutes. These legal meanings, rather than clinical meanings, apply to mental health terms used throughout this Staff Brief.

A. MENTAL ILLNESS

1. Generally

For general application of the mental health laws, "mental illness" is defined as mental disease to the extent that a mentally ill person requires care and treatment for his or her own welfare, the welfare of others or the welfare of the community [ss. 51.01 (13) (a), 51.75 (2) (d) and 55.01 (4m), Stats.].

2. Involuntary Commitment

For purposes of applying the involuntary commitment standards, mental illness is more specifically defined to mean a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but does not include alcoholism [s. 51.01 (13) (b), Stats.].

B. CHRONIC MENTAL ILLNESS

"Chronic mental illness" is defined as mental illness which is severe in degree and persistent in duration, which: (1) causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life; (2) may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support; and (3) may be of lifelong duration. Chronic mental illness includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric diagnostic categories, but does not include infirmities of aging or a primary diagnosis of mental retardation or of alcohol or drug dependence [s. 51.01 (3g), Stats.].

C. INCOMPETENT

An "incompetent person" is defined as a person adjudged by a court to be substantially incapable of managing his or her property or caring for himself or herself because of conditions incurred at any age which are the result of accident, organic brain damage, mental or physical disability or the continued consumption or absorption of substances. Physical disability, without mental incapacity, is not sufficient to establish incompetency [s. 880.01 (4), Stats.].

Specific types of conditions which may lead to incompetency include infirmities of aging and developmental disabilities. "Infirmities of aging" means organic brain damage or other physical degeneration, except for senility, caused by advanced age to the extent that the afflicted person is substantially impaired in his ability to adequately provide for his or her own care or custody. "Developmental disabilities" are defined as disabilities attributable to mental retardation, cerebral palsy, epilepsy, autism or other neurological conditions closely related to mental retardation or requiring treatment similar to that required for mentally retarded individuals, which have continued or can be expected to continue indefinitely, which substantially impair the individual from adequately providing for his or her own care or custody and which constitute a substantial handicap to the afflicted individual [s. 880.01 (2) and (5), Stats.].

D. DEVELOPMENTALLY DISABLED

The definition of "developmentally disabled," for purposes of involuntary commitment under ch. 51, Stats., is identical to its definition for purposes of establishing incompetency under ch. 880, Stats., except that, for purposes of involuntary commitment, developmental disability does not include cerebral palsy or epilepsy [s. 51.01 (5), Stats.].

PART II

LEGAL CONCEPTS

This Part of the Staff Brief describes constitutional and statutory concepts which provide the basis for the legal rights currently provided to the mentally ill in Wisconsin. It focuses on legal, rather than clinical, concepts relating to treatment of the mentally ill.

The extent to which the legal system protects the liberty interests of the mentally ill has increased over the last few decades. As will be evident from the description in Parts III and IV of the legal proceedings involved in getting a person into mental health treatment, Wisconsin law reflects the view that, under the U.S. Constitution, any mental health treatment on other than a voluntary basis is a potentially severe infringement on that person's freedom.

A. CONSTITUTIONAL RIGHTS

In order to understand the current statutory standards and procedures involved in court-ordered involuntary mental health services, it is helpful to first examine the underlying constitutional issues which arise when the state attempts to seek treatment for or restrain a person suffering from mental illness. These issues have been examined by state and federal courts primarily in the context of involuntary civil commitment to inpatient facilities. The extent to which these court decisions apply to less restrictive types of mental health treatment is still largely unsettled.

Following is an overview of the constitutional parameters, as developed, to date, by the courts.

1. Liberty Interest

The civil commitment of a mentally ill person, and particularly inpatient commitment, is recognized by the courts as a "massive curtailment" of an individual's liberty, analogous to prison incarceration. According to the courts, this curtailment of liberty not only exists in the form of limitations on the free choice of a committed person while under a commitment order, but also exists after a person has been released, in the form of stigma, discrimination and, in some jurisdictions, restrictions on certain legal privileges. Because this deprivation of liberty is potentially substantial, the 14th Amendment of the U.S. Constitution guarantees the right to due process before the state

may place someone under a commitment order. [See, for example, Humphrey v. Cady, 405 U.S. 504 (1972); Jackson v. Indiana, 406 U.S. 715 (1972); Addington v. Texas, 441 U.S. 418 (1979); and Lessard v. Schmidt, 349 F. Supp. 1078 (1972).]

In 1972, a three-judge Federal District Court for the Eastern District of Wisconsin set forth minimum due process requirements for involuntary civil commitments [Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded, 414 U.S. 473 (1974); judgment reentered, 379 F. Supp. 1376 (E.D. Wis. 1974), vacated and remanded, 421 U.S. 957 (1975), judgment reentered, 413 F. Supp. 1318 (E.D. Wis. 1976)].

The Lessard case was ultimately appealed to the U.S. Supreme Court. However, the Supreme Court did not rule on any of the substantive issues in that case and has not, to date, ruled in any other case on what grounds are required for involuntary civil commitment. The federal district court decision in Lessard remains today the most authoritative statement of the constitutional due process rights of persons subject to civil involuntary commitment.

The Lessard court's analysis compared the deprivation of liberty under a civil involuntary commitment order with criminal incarceration and found them to be substantially similar. Although the court acknowledged that a state may have distinctly different interests in confining someone under criminal versus civil proceedings, it found that the end result (i.e., the confinement) may be equally drastic in terms of curtailment of the individual's liberty interests.

The court then discussed the possible state interests in allowing the commitment of a person under Wisconsin's then-existing involuntary civil commitment procedures. These state interests included both: (a) the state's interest in protecting society against the potential dangerous acts of a person who, because of mental illness, is likely to act irrationally (the "police power"); and (b) the state's desire to seek confinement in order to treat a mentally ill person (the "parens patriae" power). In commenting on the commitment of mentally ill persons under the police power, the court noted that, under the civil commitment laws being challenged, a person could be committed based on a psychologist's prediction of the person's future dangerous behavior. Yet, the court noted, due process considerations prohibit the criminal conviction of a person based on predictions of future criminal behavior.

The court concluded that, regardless of the state's motivation for confining a person alleged to be mentally ill, the resulting deprivation of that person's liberty interest is severe enough to warrant minimal due process safeguards. The purpose of minimal due process is to ensure that the state's interest in confining the person outweighs that person's

constitutional guarantee of freedom. For the purpose of balancing these conflicting interests, minimal due process requires a finding of "an extreme likelihood that if the person is not confined he will do immediate harm to himself or others" (emphasis added). The court went on to state:

> Although attempts to predict future conduct are always difficult, and confinement based upon such a prediction must always be viewed with suspicion, we believe civil confinement can be justified in some cases if the proper burden of proof is satisfied and dangerousness is based upon a finding of a recent overt act, attempt or threat to do substantial harm to oneself or another [Lessard v. Schmidt, 349 F. Supp. 1078, at 1093; emphasis added].

The court further specified that involuntary commitment must be preceded by a finding that all available less drastic alternatives to inpatient commitment to a mental hospital or institution have been investigated and, if available, are unsuitable in a particular case.

Although the U.S. Supreme Court has, to date, not ruled on the issue of what constitutes the minimal grounds for involuntarily committing a person, the Supreme Court did, in O'Connor v. Donaldson, 422 U.S. 563 (1975), provide language often cited by other courts in determining whether a state's commitment standards are constitutional. Although, in O'Connor, the Supreme Court was not specifically ruling on the constitutionality of civilly committing an individual for the purpose of treatment, without a prior finding of dangerousness, the Court stated:

> A finding of "mental illness" alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the "mentally ill" can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.
>
> May the State confine the mentally ill merely to ensure them a living standard superior to that they enjoy in the private community? That the State has a proper interest in providing care and assistance to the unfortunate goes without saying. But the mere presence of mental illness does not disqualify a person from preferring his home to the comforts

> of an institution. Moreover, while the State may arguably confine a person to save him from harm, incarceration is rarely if ever a necessary condition for raising the living standards of those capable of surviving safely in freedom, on their own or with the help of family or friends [O'Connor, at 575].

2. Least Restrictive Setting

The Lessard court also held that full-time inpatient commitment should be ordered only as a last resort. In this regard, the Lessard court stated:

> A basic concept in American justice is the principle that even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose.... Perhaps the most basic and fundamental right is the right to be free from unwanted restraint. It seems clear, then, that persons suffering from the condition of being mentally ill, but who are not alleged to have committed any crime, cannot be totally deprived of their liberty if there are less drastic means for achieving the same basic goal [citations omitted; Lessard, 349 F. Supp., at 1095 to 1096].

The Lessard court imposed upon the state the burden of investigating all available alternatives to inpatient commitment and establishing their lack of availability and suitability prior to committing someone involuntarily to inpatient treatment.

3. Procedural Due Process

Upon order from the Court of Appeals for the 7th Circuit, the federal district court in Lessard enumerated the following specific procedural due process rights to which an alleged mentally ill person is entitled in involuntary civil commitment proceedings:

a. Written and oral notice of the following: (1) the right not to converse with examining physicians and the fact that anything said may be used as evidence against him or her at the final commitment hearing; (2) the right to counsel both at the hearing and, in the case of a stipulated agreement before the final order of the court, in consultation before consenting to voluntary admission; (3) the right to refuse medication which would interfere with the person's ability to defend himself or herself during the proceedings; and (4) the right to jury trial at the final hearing;

b. Written and oral notice of the time and place of the probable cause hearing and the factual basis for detention;

c. A probable cause hearing within 48 hours of detention (excluding weekends and holidays), at which time the subject of the proceedings has the unwaivable right to be present and to have counsel present;

d. Notice of: (1) the date, time and place of the final commitment hearing; (2) the factual basis alleged in the commitment petition; (3) the minimum standards of involuntary commitment (mental illness and dangerousness); and (4) the names and opinions of all examining physicians testifying in the commitment proceedings;

e. Within 14 days of the original detention, a full adversary hearing, comporting with the rules of evidence, including the hearsay rule, at which the person has the right to be present and represented by counsel. At this final hearing, the state has the burden of proving beyond a reasonable doubt that the subject meets the commitment standards based, at a minimum, on a recent act, attempt or threat to do substantial harm. The state must also show that less drastic alternatives to inpatient commitment have been investigated and are unsuitable or unavailable [Lessard v. Schmidt, 379 F. Supp. 1376 (E.D. Wis. 1974)].

4. Humane Conditions and Minimally Adequate Treatment

Once a person has been involuntarily committed under proper procedures, and consistent with constitutional liberty interests, courts have found that the person also has constitutionally-protected interests in humane conditions of confinement such as adequate food, shelter, clothing and medical care. The person also has a constitutionally-protected right to be free from bodily restraint [Vitek v. Jones, 445 U.S. 480 (1980); Youngberg v. Romeo, 457 U.S. 307 (1982)].

The U.S. Supreme Court has determined that mentally retarded persons involuntarily committed to inpatient mental health facilities are entitled to minimally adequate training to the extent that such training may be

reasonable in light of that person's liberty interests in safety and freedom from unreasonable restraint. The Supreme Court said that, in determining what level of training is proper, courts must defer to the professional judgment of persons making treatment decisions; these decisions are entitled to a presumption of correctness [Youngberg v. Romeo, 457 U.S. 307 (1982)].

Lower federal courts have extended the U.S. Supreme Court's reasoning in Youngberg to treatment for mentally ill persons involuntarily committed in inpatient treatment facilities. For example, the U.S. Court of Appeals for the 2nd Circuit has held that:

> The massive curtailment of liberty associated with involuntary confinement dictates that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed. If the justification for commitment rests, even in part, upon the need for care and treatment...then a State which commits must also treat [citations omitted; Woe v. Cuomo, 729 F. 2d 96 (2nd Cir. 1984), at 105].

To date, however, no state or federal court having jurisdiction over Wisconsin has decided to what extent persons involuntarily committed (or protectively placed) under Wisconsin law have the right to a specified level of treatment.

5. Refusal of Treatment

Several jurisdictions, including Wisconsin, have statutorily recognized a limited right of mental health patients to refuse treatment. Several courts have recognized a qualified right under the U.S. Constitution of mental health patients to refuse treatment. However, no court has determined precisely how far this right extends or what due process safeguards are required before a state may override this right.

Mental health patients asserting a constitutional right to refuse treatment generally invoke the rights to privacy and freedom of thought under the First Amendment of the U.S. Constitution and the right to be free from cruel and unusual punishment under the 8th Amendment. Lawsuits have generally arisen when involuntarily committed persons are forcibly treated with psychotropic drugs. A number of federal courts have held that involuntarily committed mentally ill persons have a qualified right to refuse psychotropic drugs under state statutes and the U.S. Constitution.

The U.S. Court of Appeals for the 3rd Circuit held that a patient who is committed involuntarily to a state institution retains the right to refuse psychotropic drugs when the drugs pose a substantial risk to his or her well-being, such as by causing permanently disabling side effects. However, the Court held that the state may override this right to the extent that the state has a legitimate governmental concern and obligation [Rennie v. Klein, 563 F. 2d 836, vacated and remanded, 458 U.S. 1119, 720 F. 2d 266 (3rd Cir. 1983)]. A similar conclusion was reached by the U.S. Court of Appeals for the First Circuit in Rogers v. Okin, 738 F. 2d 1 (1st Cir. 1984).

The Rennie and Rogers Courts did not determine precisely what due process procedures must be followed before a patient may be given psychotropic drugs involuntarily, because they found that the state laws in question exceeded minimal due process requirements.

The U.S. Supreme Court has indicated, at least implicitly, that if an involuntarily committed mentally ill person has a right to refuse psychotropic drugs, a court must defer to the professional judgment of the person prescribing the use of the drugs. According to the Supreme Court, interference by the federal judiciary with the internal operations of mental health institutions should be minimal. Treatment decisions made by mental health professionals are presumptively valid and may be overturned only upon a showing that the professional judgment is such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on an accepted, professional judgment [Youngberg v. Romeo, 457 U.S. 307, at 322 to 323 (1982)].

There have been two decisions issued by federal courts with jurisdiction over Wisconsin relating to the forcible administration of psychotropic drugs to mental health patients.

In a 1985 decision, the Federal District Court for the Western District of Wisconsin upheld, as constitutional, Wisconsin's statute allowing administration of psychotropic drugs to mentally ill persons under criminal commitment. The plaintiff had been committed to Mendota Mental Health Institute in 1974 after a verdict of "not guilty by reason of mental disease or defect" in a first-degree murder trial. The plaintiff acknowledged that the psychotropic drug treatment was administered according to statutory guidelines; however, the plaintiff alleged that the Wisconsin statutory scheme violated his constitutional liberty interest by failing to provide adequate due process as required under the 14th Amendment.

The district court found that both criminally and civilly committed persons have a valid liberty interest in not being treated against their

will. The court further found, however, that Wisconsin statutes provide adequate due process protection of this liberty interest.

First, the court concluded that criminal commitment procedure itself provides adequate due process protection before a person may be involuntarily committed. Included as part of this process is a hearing and determination on whether the subject of the commitment proceedings may be forced to undergo psychiatric treatment. The court found that nonconsensual treatment by means of psychotropic drugs is clearly within the scope of psychiatric treatment in the contemplation of the committing court.

Second, the court found that Wisconsin's involuntary commitment statutes expressly provide means to assure that psychotropic drugs are administered only in a professionally-acceptable manner, even though they may be administered against the will of the patient. According to the district court, this is the sole criterion mandated by the U.S. Supreme Court in the Youngberg decision, discussed above [Stensvad v. Reivitz, 601 F. Supp. 128 (W.D. Wis. 1985)].

In a 1983 case, the U.S. Court of Appeals for the 7th Circuit, which includes Wisconsin, discussed the right of a patient, who is voluntarily admitted to a psychiatric facility and who has been found incompetent to make treatment decisions, to refuse certain types of treatment. The treatment in this case involved the administration of electroconvulsive therapy (ECT), rather than psychotropic drugs.

First, the Court found that, for purposes of its analysis of the right to refuse treatment, the distinction between voluntary and involuntary patients is irrelevant. Second, the Court found that a patient's incompetency has no bearing on that person's liberty interests; it only alters whether the decision to refuse treatment is made by the patient or by a guardian appointed to act in the patient's best interests. Unfortunately, the Court did not then delineate the minimal due process requirements but, rather, remanded the case to the trial court on various procedural grounds. The Court did, however, direct the trial court to determine whether the defendant's decision to administer ECT departed from accepted professional practice, using the standard set forth by the U.S. Supreme Court in Youngberg [Lojuk v. Quandt, 706 F. 2d 1456 (7th Cir. 1983)].

6. Release

It is generally accepted by the courts that, if a person may not be committed unless the minimum standards required under the 14th Amendment are met, then neither may a person continue to be detained under a

commitment order once that person no longer meets the commitment standards. This is especially true for acutely, rather than chronically, mentally ill persons whose illnesses are transitory or treatable. Accordingly, the courts have held that involuntarily committed persons have a right to periodic review of their commitment and to be released upon a finding that they no longer meet the minimum standards for commitment. Periodic reevaluation is also required to determine whether the committed individual is eligible for transfer to a less restrictive setting [see, generally, O'Connor v. Donaldson, 422 U.S. 563 (1975) and State ex rel. Watts v. Combined Community Services Board of Milwaukee County, 122 Wis. 2d 65 (1985)].

B. STATUTORY RIGHTS

The constitutional rights of recipients of mental health services, described in Section A of this Part, are codified throughout the Wisconsin statutes governing involuntary commitment, protective services and protective placement. Those statutes are described in Part III of this Brief. In addition to these basic constitutional rights, the Wisconsin statutes also provide for those rights of mental health patients described below:

1. Conditions of Confinement

Section 51.61, Stats., sets forth the rights to which any individual is entitled who is receiving services in Wisconsin for mental illness, developmental disabilities, alcoholism or drug dependency. These rights apply regardless of whether the patient is voluntarily admitted, involuntarily committed or protectively placed and apply to patients in private, as well as public, facilities. The rights enumerated in s. 51.61, Stats., include the right, subject to certain limitations, to:

a. Refuse to perform labor which financially benefits the treatment facility;

b. Send and receive sealed mail;

c. Petition a court to review any commitment order except for orders of commitment for treatment of alcoholism;

d. Be subject to the least restrictive conditions necessary to achieve the purpose of the admission, commitment or placement;

e. Receive prompt and adequate treatment, including appropriate rehabilitation and educational services;

f. Refuse all medication and treatment, except under court order or for the prevention of serious harm to self or others;

g. Be free from unnecessary or excessive medication at any time;

h. Be free from physical restraint and isolation, except for emergency situations, as part of treatment or under certain other specified circumstances;

i. Not be subjected to experimental research without informed consent;

j. Not be subjected to drastic treatment procedures without express and informed consent, including psychosurgery and electroconvulsive treatment;

k. Have the opportunity for religious worship, where available;

l. Have a humane psychological and physical environment;

m. Have records of his or her treatment kept confidential;

n. Not be filmed or taped without informed consent;

o. Make and receive telephone calls;

p. Use and wear the patient's own clothing and personal articles;

q. Have access to storage space;

r. Have privacy when toileting and bathing; and

s. See visitors each day.

2. Periodic Review of Placement

Involuntarily committed persons may not be committed for more than six months initially, and subsequent consecutive orders of commitment of the individual may be for periods not to exceed one year. A second or subsequent order of commitment may be made only upon a review and a separate finding by the court that the individual continues to meet the commitment standards. The county mental health board has the ongoing responsibility to review the committed individual's condition and to transfer the person to the least restrictive setting consistent with those needs [s. 51.20 (13) (f) and (g) and (17), Stats.].

Protectively placed individuals are also entitled to automatic, regular review of their placement, although the initial placement order may be for an indefinite period of time. At least annually, a guardian ad litem must review the evaluation of the county protective services agency, assist the protectively placed person in determining whether an independent evaluation is necessary and whether to seek a court hearing on the issue of continued need for protective placement and file a report with the court. The court must review the report by the guardian ad litem, although a full adversary hearing is not necessary [s. 55.06 (10), Stats; State ex rel. Watts v. Combined Community Services Board of Milwaukee County, 122 Wis. 2d 65 (1985)].

3. Confidentiality of Records

a. General Rule

The confidentiality of mental health patients' treatment records, including the administrative records of treatment facilities, county boards and the Department of Health and Social Services (DHSS), is governed by s. 51.30, Stats. As a general rule, all treatment records are confidential and may be released only upon informed written consent of the person being treated.

b. Exceptions

There are a number of exceptions to the general rule of confidentiality which permit the release of treatment records, without written consent, for the following purposes, subject to certain limitations:

(1) For program audits and evaluations;

(2) For billing purposes;

(3) For the purposes of research;

(4) Pursuant to a court order;

(5) For periodic review of the patient's progress, adequacy of treatment and placement;

(6) To persons working at the facility, to the extent necessary for them to perform their duties;

(7) Within the DHSS, where necessary to coordinate treatment for persons under its jurisdiction;

(8) To a licensed physician in emergency situations;

(9) In the case of discharge or transfer of the patient; to authorized persons (such as legal counsel, guardians ad litem, correctional officers, public defenders or law enforcement officers); and

(10) To persons needing to establish whether an individual is on unauthorized absence from a facility.

Release under any of these exceptions must be limited wherever possible to assure the confidentiality of information and prevent unwarranted disclosure to unauthorized persons. The custodian of treatment records must make a notation in the record whenever that record is released [s. 51.30 (4) (b), Stats.].

c. Patient's Access to Own Records; Correction of Records

Section 51.30, Stats., also provides for the patient's access to his or her own treatment records. Following discharge, the patient must be allowed access to all treatment records, subject to reasonable costs of reproduction of records. During the patient's treatment, access to the treatment records may be restricted, except for records of medications and somatic treatments received by the patient. The patient, or his or her parent or guardian, may challenge the accuracy, completeness, timeliness and relevance of information in treatment records. Procedures are included for correcting information or, if a requested change in the records is denied, for the person challenging the record to insert a statement into the records [s. 51.30 (4) (d) and (f), Stats.].

d. Court Records

Records of involuntary commitment court proceedings are closed, except to the person who is the subject of the proceeding, the person's attorney or the guardian ad litem. Otherwise, the patient's informed written consent or a court order is required before court records may be released to any other person [s. 51.30 (3), Stats.].

e. Sanctions for Breach of Confidentiality

If any statutory provision relating to the confidentiality of records is violated, any person damaged as a result of the violation may bring a grievance procedure, a civil action or both against the person violating the confidentiality provisions. A plaintiff in any civil action may seek actual damages, exemplary (punitive) damages, an injunction or any combination of these remedies and is entitled to court costs and reasonable attorney fees if he or she prevails [s. 51.20 (9), Stats.].

PART III

OBTAINING TREATMENT AND CARE FOR THE MENTALLY ILL: STANDARDS AND PROCEDURES

This Part of the Brief describes the various statutory civil procedures available to obtain mental health treatment or care, either involuntarily or voluntarily. Court proceedings, which are necessary to obtain involuntary care or treatment, include commitment, recommitment, protective placement and protective services. Related court proceedings are also described for temporary inpatient detention and guardianship or conservatorship. Voluntary admission to an inpatient facility, although not always involving court proceedings, must follow the statutory procedures also described in this Part.

A. INVOLUNTARY COMMITMENT

The statutes require an adversary civil court proceeding for involuntary treatment. Under the statutory procedures, the decision to involuntarily commit a person is made by an objective decision-maker (the judge) based on professional opinions, factual evidence and a balancing of the interests of the state and the interests of the person alleged to be mentally ill. Although involuntary commitment is a civil, rather than criminal procedure, many of the procedural safeguards provided are patterned upon criminal procedures, reflecting the rights of persons not to be deprived of liberty without due process. As with criminal proceedings, the subject of involuntary civil commitment is presumed to be entitled to his or her personal freedom, until the state, on behalf of the persons seeking commitment, proves otherwise.

1. Standards for Involuntary Commitment

The purpose of an involuntary commitment hearing is to determine whether an individual who has not consented to voluntary admission for mental health treatment meets the criteria for being ordered by the state to receive some type of mental health care. There are three statutory criteria which must be proved by the state before a person may be involuntarily committed. The person must be shown to be:

a. Mentally ill, drug dependent or developmentally disabled;

b. A proper subject for treatment; and

c. Dangerous, under at least one of four standards of dangerousness [s. 51.20 (1) (a), Stats.]. Each of these criteria is discussed separately.

a. Mentally Ill

This discussion of involuntary commitment focuses on commitment of the mentally ill; commitment of the drug dependent and developmentally disabled are not covered in this Staff Brief. As indicated in Part I, A, of this Brief, ch. 51, Stats., provides two definitions of mental illness. One, a general definition, refers to a person's need for treatment and inability to care for himself or herself. For the purposes of meeting the involuntary commitment criteria, however, mental illness is more specifically defined as "a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life..." [s. 51.02 (13) (b), Stats.].

It should be noted that, even though a person may meet the definition of mentally ill and be involuntarily committed, that person is not necessarily legally incompetent. The distinction between these two terms is one of duration, rather than severity, of the impairment. Commitments under ch. 51 are primarily intended for persons with acute mental illnesses, whereas other alternatives, such as protective placement and guardianship, are available for persons with long-term, or chronic, mental illnesses who meet the definition of "incompetent" [s. 51.59, Stats.].

b. Proper Subject for Treatment

This criterion highlights one of the purposes for involuntary commitment--treatment of the mental illness. For purposes of this criterion, "treatment" is defined to mean "those psychological, educational, social, chemical, medical or somatic techniques designed to bring about rehabilitation of a mentally ill...person" [s. 51.01 (17), Stats.].

The term "rehabilitation" has been construed by the Wisconsin Courts of Appeals for the 1st and 2nd Appellate Districts to mean something more than simply maintaining a minimum level of functioning, but does not necessarily require a determination that the person is capable of being cured. Controlling symptoms may be a proper component of rehabilitation [In Matter of Mental Condition of C.J., 120 Wis. 2d 355, 354 N.W. 2d 219 (Ct. App., 1984); In Matter of Athans, 107 Wis. 2d 331, 320 N.W. 2d 30 (Ct. App., 1982)].

c. Dangerousness

Prior to ordering an involuntary commitment, a court must make a finding that the person is dangerous under one or more of the following four standards:

(1) There is a substantial probability that the person will physically harm himself or herself. This probability must be supported by evidence of recent threats or of attempts at suicide or serious bodily harm [s. 51.20 (1) (a) 2 a, Stats.].

(2) There is a substantial probability that a person will physically harm other individuals. This probability must be supported by evidence of recent homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them because of a recent overt act, attempt or threat on the part of the subject of the commitment proceedings to do serious physical harm [s. 51.20 (1) (a) 2 b, Stats.].

(3) The person's judgment is impaired to the extent that there is a substantial probability of physical impairment or injury to himself or herself. This standard is not met in cases where there are adequate community resources available for that person's protection. Impaired judgment must be shown by evidence of a pattern of recent acts or omissions [s. 51.20 (1) (a) 2 c, Stats.].

(4) The person is unable to satisfy his or her basic needs for nourishment, medical care, shelter or safety, because of mental illness, unless the person receives prompt and adequate treatment. Under this standard, there must be a substantial probability that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the person receives prompt and adequate mental health treatment. The person's inability to satisfy his or her basic needs must be shown by recent acts or omissions. As with standard (3), above, a person may not be committed under the "unable to satisfy basic needs" standard if there is adequate treatment and protection available in the community or if the person is appropriate for protective placement under ch. 55, Stats. [s. 51.20 (1) (a) 2 d, Stats.].

2. Alternative Standards for Involuntary Commitment

Alternatives to the standards discussed above are provided for involuntary commitments under the following special circumstances:

a. For Probable Cause Finding or Detention

For purposes of finding probable cause to continue a commitment hearing and for purposes of detaining a person pending the final commitment order, but not for purposes of the final commitment determination, a court may proceed in a commitment hearing if the subject of the hearing is: mentally ill, drug dependent, or developmentally disabled; is a proper subject for treatment; and evidences such impaired judgment, manifested by evidence of a recent act or omission, that there is a substantial probability of physical impairment or injury to himself or herself. This standard allows the court to proceed based on a single recent act or omission, rather than a series or pattern of recent acts or omissions [s. 51.20 (1m), Stats.].

b. Predictions Based on Past Treatment Records

The standards of dangerousness may be satisfied by a prediction, based on past treatment records, that the person would be a proper subject for commitment if treatment were withdrawn, under the following circumstances:

(1) The person has received inpatient treatment for mental illness, developmental disability or drug dependency, either voluntarily or under a commitment or placement order; or

(2) The individual has received court-ordered outpatient treatment for mental illness, developmental disability or drug dependency immediately prior to commencement of the current commitment proceeding [s. 51.20 (1) (am), Stats.].

c. Acts Prior to Inpatient Admission or Incarceration

For persons who have been receiving inpatient mental health treatment, or have been incarcerated in a jail or prison, immediately prior to the commitment proceedings, the acts or omissions on which the commitment order is based may have occurred prior to the person's admission or incarceration [s. 51.20 (1) (am), Stats.].

d. Dangerousness Exception for Inmates

If the person is an inmate of a state prison, a commitment may be ordered based on a finding that he or she is mentally ill, is a proper

subject for treatment and is in need of treatment. A showing of dangerousness is not required. It must be shown that less restrictive forms of treatment of the inmate have been unsuccessfully attempted. Commitments of inmates may be on either an inpatient or outpatient basis. This separate standard for inmates may not be used after July 1, 1987 [s. 51.20 (1) (ar), Stats.].

3. Involuntary Civil Commitment Procedures

Under statutory procedures for involuntary commitment, the court must first decide, based on facts alleged in the petition for commitment, whether the subject of the action should be detained in an inpatient facility pending the outcome of the commitment hearing. Next, the court must determine, based on its examination of the petition, whether probable cause exists to continue the commitment proceedings. Finally, the court, after ordering an independent examination of the subject of the proceedings, must determine whether the subject meets the standards for commitment and, if so, what type of treatment is most appropriate.

Following a chronological description of the statutory involuntary commitment procedures:

a. Commencement of Commitment Hearing

An involuntary commitment hearing may be commenced in one of two ways: by petition or by emergency detention.

(1) Petition. A petition for involuntary commitment must be signed by three adults, at least one of whom has personal knowledge of the conduct of the subject of the commitment proceedings. The petition must allege that the subject meets the criteria for commitment, including at least one of the dangerousness standards. Specific facts supporting the allegation of dangerousness must be included in the petition. The petition must also include names and addresses of all known close relatives of the subject, to the extent known [s. 51.20 (1) (a) and (c), Stats.].

(2) Emergency detention. Emergency detention of a person may be accomplished by a law enforcement officer, without a prior court hearing, for brief periods of time pending the filing of a petition for involuntary commitment. A law enforcement officer may take a person into detention if the officer has cause to believe that the person is mentally ill, developmentally disabled or drug dependent and evidences one of the four standards of dangerousness applicable to involuntary commitment.

Dangerousness, for purposes of emergency detention, may be shown by a single recent act or omission rather than a series or pattern of recent acts or omissions; the specific acts or omissions need not be observed personally by the law enforcement officer, but may be observed by another and reliably reported to the officer.

The officer must deliver the person to a treatment facility along with a statement explaining why the officer believes the person should be detained. In Milwaukee County, the treatment facility director must examine the person within 24 hours and, if appropriate, may continue to detain the person for no more than a total of 72 hours. During this 72-hour period, the director must file a petition for commitment with a court to commence commitment proceedings. In other counties, the statement filed with the facility by the law enforcement officer constitutes a petition for involuntary commitment; the facility may not detain the person for more than 72 hours unless a hearing is held to determine probable cause under the involuntary commitment or protective placement procedures.

For persons voluntarily admitted to treatment facilities, the facility director may act as a law enforcement officer for purposes of detaining the person in the facility involuntarily under the emergency detention procedures [s. 51.15, Stats.].

b. Detention Pending Final Order

In any involuntary commitment proceedings, whether commenced by a three-party petition or emergency detention, the court must issue a notice of any future court hearings held during the commitment process and determine whether the subject should be detained pending the court's final order. The subject may not be detained pending the final order unless the court finds cause to believe that, based on specific, recent overt acts, attempts or threats to act or on a pattern of recent acts or omissions, the subject meets the standards for commitment.

If the court does not order detention, the law enforcement officer serving the notices of involuntary commitment hearings may, nonetheless, decide to detain the individual, applying the same standards applied by the court.

If the subject is detained by court order, or by the law enforcement officer, the detention may take place at an approved public treatment facility, a mental health institute, a center for the developmentally disabled, a state treatment facility or an approved private treatment facility if the private facility agrees to detain the subject.

If the subject is detained at this point in the proceedings, the next step (the probable cause hearing) must be held within 72 hours after the subject is detained, excluding weekends and holidays. Otherwise, a probable cause hearing must be held within a "reasonable time" of the filing of the petition [s. 51.20 (2), Stats.].

c. Probable Cause Hearing

The court must, within the time limits described in the preceding paragraph, hold a hearing to determine whether there is probable cause to believe the allegations in the petition or, in the case of emergency detentions, statements made by the law enforcement officer at the time of the detention. The subject must appear at the probable cause hearing; if the subject fails to appear, the court may issue a detention order and convene again within 48 hours of detention to hold the probable cause hearing.

The court may take one of three actions after the probable cause hearing. If the court finds probable cause for involuntary commitment, it may continue on to the next step in the proceedings (the final hearing). If the court finds probable cause for protective services, rather than for civil commitment, it may proceed under ch. 55. If the court finds no probable cause to issue a commitment order, it must dismiss the proceedings and release the subject if the subject has been detained [s. 51.20 (7), Stats.].

d. Disposition Pending Hearing

If a court finds probable cause to continue on to the final commitment hearing, the court may again determine whether to detain or release the subject pending the final commitment order. At this point, the court may release the subject from detention, may continue full detention or may release the subject under certain conditions. These conditions may include treatment at an outpatient facility, with inpatient detention as the consequence for violating the conditions of release. However, the subject retains the right to refuse treatment at all times pending final commitment order, although refusal of treatment at this point would probably result in detention.

e. Court-Ordered Examination

After a court has found probable cause to continue, and before the final hearing, the court must appoint two physicians or psychiatrists, or one of each, to examine the subject. One of these examiners may be selected by the subject; the subject also has the right to select a third examiner at his or her own expense (or the state's expense, if the subject is found indigent by the court).

The function of the examiners is to examine the subject and submit their professional opinions to the court. Before the examination, the subject must be informed of his or her right to remain silent. However, the examiners must submit a written report to the court, even if the subject exercises his or her right to remain silent. In addition to personal examination of the subject, the examiners are entitled to have access to the subject's previous treatment records.

The report must contain the examiner's opinion, to a degree of professional certainty, regarding the existence of the standards for commitment (mental illness, proper subject for treatment and dangerousness) and the appropriateness of various types of treatment and treatment facilities. The report must also include a recommendation concerning the level of treatment and the appropriate facility which would provide the least restrictive environment consistent with the needs of the subject.

In addition to the reports of the court-ordered examiners, both parties are entitled to discovery of any other evidence the opposing party intends to use in court [s. 51.20 (9), Stats.].

f. Final Commitment Hearing and Disposition

The purpose of the final commitment hearing is to determine, based on all the evidence before the court, whether the subject meets one or more of the commitment standards. This hearing may, at the the option of the subject of the commitment, be a jury trial, with a six-member jury, or a trial without a jury. The subject has the right to be represented by counsel at the final commitment hearing, as well as the right to either an open or closed hearing.

The subject must be present at the final commitment hearing. If the subject does not appear, the court may order the subject's detention and reconvene the hearing within seven days of the detention.

The judge has several options at the final commitment hearing. Based on the judge's or jury's findings of fact, the judge may: dismiss the petition; find that protective placement, and not involuntary commitment, is appropriate; or commit the subject to the county mental health board and order inpatient commitment or outpatient commitment. If the subject of the hearing is a prison inmate at the time of the proceedings, or is a nonresident of the state, and mental health commitment is appropriate, the court commits the person to the custody of the DHSS.

If the court finds that the subject's dangerousness may be controlled on an outpatient commitment basis, the court may order commitment with a conditional release. Under this arrangement, the court may order the

individual to comply with medication and visitation orders. If the individual fails to comply with these orders, he or she may be taken into custody and forcibly medicated [s. 51.20 (13), Stats.].

g. Rights of Committed Individual After Final Order

After a final commitment order has been issued, the committed individual may exercise the following options: appeal the final order; seek a reexamination by a physician or psychiatrist; or seek a modification or cancellation of the court order [s. 51.20 (15) and (16), Stats.].

Every committed individual is statutorily required to be reevaluated by a physician or psychiatrist within 30 days of the commitment, within three months of the initial reevaluation and every six months thereafter, to determine whether the individual may be transferred to a less restrictive facility or discharged [s. 51.20 (17), Stats.].

h. Transfer

Generally, transfer of an involuntarily committed individual to a less restrictive facility requires approval of the county mental health board but no court hearing or order. Transfer to a less restrictive facility may be subject to certain conditions, such as taking medications and receiving other forms of treatment.

Transfer to a more restrictive setting requires notice to the person of his or her right to contact an attorney and to petition the court for a review of the transfer [s. 51.35 (1), Stats.].

4. Commitment Periods; Extensions

Commitments may be ordered for limited periods of time. Commitments under the "dangerous to self," "dangerous to others" or "impaired judgment" standards of dangerousness may be initially committed for not longer than six months and may have their commitments extended for periods of not more than one year. Commitments under the "unable to satisfy basic needs" standard of dangerousness may not continue longer than 45 days in any first 365-day period; after the first year, commitments may extend for more than 45 days within a 365-day period [s. 51.20 (13) (g), Stats.; In Matter of M.J., 122 Wis. 2d 525 (Ct. App. 1984)].

For extensions of a commitment beyond the statutory periods, the county mental health board (or, in the case of an inmate or nonresident, the DHSS) must petition the court for an extension order. The procedure followed by the court in extending an order of commitment is the same as

the final commitment hearing procedure for initial commitments, described above.

B. TEMPORARY INPATIENT DETENTION

There are several procedures under which a person may be taken involuntarily into custody for mental health treatment, for limited periods of time, without a prior court proceeding. These temporary measures include emergency detention, temporary admission pending appointment of a guardian and short-term admission of minors.

1. Emergency Detention

Emergency detention is discussed more fully in the context of commencement of a commitment hearing, in Section A, 3, a, 2, of this Part. Emergency detention of an individual must be based on a belief that the individual meets the involuntary commitment criteria. Detention of a person under these emergency procedures may not exceed 72 hours unless a court hearing is held within that period to determine whether probable cause exists to involuntarily commit or protectively place the person [s. 51.15, Stats.].

2. Temporary Admission Pending Appointment of a Guardian

A treatment director of a mental health inpatient facility may temporarily admit an individual when there is reason to question the individual's competency. This procedure may be used in cases where there is reason to believe the individual is incompetent and unable to consent, before incompetency has been determined by a court and before a guardian has been appointed.

A person may not be detained under this provision for more than 48 hours, excluding weekends and holidays, unless application for court appointment of a guardian is made within that time. Once application is made, however, the individual may remain at the facility pending appointment of a guardian, which involves a court proceeding under ch. 880, Stats., discussed in Section G, 1, of this Part [s. 51.10 (7), Stats.].

3. Short-Term Admission of Minors

A minor under the age of 14 may be admitted, without his or her consent, to an inpatient facility for the purposes of diagnosis and

evaluation or for dental, medical or psychiatric services. The minor's parent or guardian must consent to, and apply for, this type of admission. A minor over the age of 14 may not be admitted under this provision without his or her consent.

Admission under this provision may not be for a period in excess of 12 days, and no one may be admitted under this provision more than once in any 120-day period. After 12 days, the minor must be released unless an application for voluntary admission or a petition for emergency detention, involuntary commitment or protective placement has been filed [s. 51.13 (6), Stats.].

C. PROTECTIVE PLACEMENT

Protective placement is a placement of a person determined to be incompetent (referred to as a "ward"), in a long-term care facility for the primary purpose of obtaining care for, and custody over, the ward. Protective placement and involuntary commitment differ in a number of ways: first, protective placement requires a previous or concurrent finding of incompetency; second, different standards are used for determining whether protective placement is appropriate; and third, a protective placement order is to a long-term residential care facility, whereas a civil commitment order may be to an acute psychiatric treatment facility [see, generally, s. 55.06, Stats.].

1. Standards for Protective Placement

Protective placement may be ordered for a person who has been found, as a result of a court proceeding, to:

a. Have a primary need for residential care and custody;

b. Be incompetent (see the definition of incompetent in Part I, C; a finding of incompetency is not required for a minor who is developmentally disabled);

c. Be totally incapable of providing for his or her own care or custody because of his or her incapacity, such that there is a substantial risk of serious harm to himself or herself or to others; and

d. Have a disability which is permanent or likely to be permanent. The types of disabilities for which protective placement may be appropriate include chronic mental illness, developmental disabilities, infirmities of aging, accidental or organic brain damage or disabilities caused by substance abuse [s. 55.06 (2), Stats.].

2. Protective Placement Procedures

a. Commencement of Court Proceedings

Protective placement must be instituted by a petition alleging that the subject of the proceedings meets the standards for protective placement. This petition may be signed by the DHSS, a public or private board, corporation or association which is concerned with the specific needs and problems of mentally retarded, developmentally disabled, mentally ill, alcoholic, drug dependent and aging persons, a guardian or any interested person [s. 55.06 (2) and (3), Stats.].

If the person has not been declared incompetent by a court prior to the protective placement proceeding, a petition for guardianship must be filed and a guardian appointed prior to an order of protective placement. A guardianship based on incompetency which was ordered more than one year prior to the protective placement petition must be reviewed by the court. For a brief discussion of incompetency proceedings and the appointment of a guardian, see Section G, 1, of this Part [s. 55.06 (4), Stats.].

b. Notice and Rights

The person for whom protective placement is being sought must be notified of the proceedings, as well as relatives or other appropriate persons and any group or organization giving aid to the person. The person must be informed of his or her right to a jury trial of the issue of incompetency and the right to legal counsel throughout the proceedings [s. 55.06 (6), Stats.].

c. Multidisciplinary Evaluation

The court must order a comprehensive, multidisciplinary evaluation of the person. A copy of the evaluation report must be provided to the person, the person's guardian and legal counsel at least 96 hours before the final placement hearing. The report must include specific findings regarding the person's medical, psychological, social, vocational and educational needs and relevant treatment history, as well as any recommendations on whether the person should maintain full or partial legal rights and the recommendations for placement consistent with the least restrictive environment required [s. 55.06 (8), Stats.].

d. Hearing and Disposition

Unlike involuntary commitment, no separate probable cause hearing is required in protective placement proceedings. The person has the right to appear, to cross-examine witnesses and to be represented by legal counsel at the placement hearing. If the court finds, by clear and convincing

evidence, that the person meets the protective placement standards, the court may order the person placed in an appropriate facility.

Appropriate facilities include nursing homes, public medical institutions, centers for the developmentally disabled, foster care services and other home placements, but not units for the acutely mentally ill. While in a facility, a protectively placed individual has the rights described in Part II, B, 1, of this Brief [s. 55.26 (9), Stats.].

e. Periodic Review of Placement

Unlike involuntary commitments, there is no specific time limitation on an initial or any subsequent protective placement. The county protective services agency is, however, required to annually review the person's placement to determine whether the placement remains appropriate.

The court which ordered the placement must appoint a guardian ad litem to meet annually with the placed person, to review the county agency's report and to explain to the person and to the person's guardian the right to have an attorney appointed, the right to have an independent evaluation of the person's condition and the right to request a full due process hearing on the need for continued placement or the appropriateness of the present placement. The guardian ad litem may request a new evaluation of the individual, if it appears necessary, and must make a recommendation to the court regarding whether the person continues to meet the standards for protective placement or whether a full hearing should be held on the matter. The court may also order a hearing on its own initiative [s. 55.06 (10), Stats.; see, also, State ex rel. Watts v. Combined Community Services Board of Milwaukee County, 122 Wis. 2d 65 (1985)].

f. Transfer

No court approval is necessary to transfer a protectively placed person between placement facilities. Advance notice of any transfer must be provided to the person, the person's guardian, the court and the county protective services agency. A hearing must be held on the transfer upon request by any interested person.

A person may not be involuntarily transferred to an acute psychiatric unit for diagnosis or treatment without first having a commitment hearing, nor may a guardian consent to such a transfer on the ward's behalf [s. 55.06 (9), Stats.; see, also, State ex rel. Watts v. Combined Community Services Board of Milwaukee County, 122 Wis. 2d 65 (1985)].

g. Discharge

If, during the course of the annual review of the placement or, upon petition for termination of a placement by any interested person, it appears that the person no longer meets the standards for placement, or in the event that a court terminates a guardianship order, the placement order must be terminated. Prior to discharge, the county protective services agency must review the person's needs for any continued protective services and for continued guardianship after discharge [s. 55.06 (10) and (14), Stats.].

D. EMERGENCY PLACEMENT

A person may be taken into custody and transmitted to an appropriate medical or protective placement facility if it appears probable that he or she will suffer irreparable injury or death as a result of developmental disabilities, infirmities of aging, chronic mental illness or similar incapacities if not immediately placed. An emergency placement may be made by a sheriff, police officer, fire fighter, guardian or authorized representative of a county board or designated agency upon personal observation of the emergency. A petition for protective placement must then be filed and a probable cause hearing must be held within 72 hours of the detention [s. 55.06 (11), Stats.].

E. PROTECTIVE SERVICES

Whereas a protective placement is for the purpose of placing an individual in a residential setting commensurate with his or her need for care and treatment, protective services are services such as outreach, needs assessment, social services, legal services, diagnostic evaluation and general assistance in needs of daily living which do not necessarily require a residential placement. The DHSS is statutorily directed to develop a statewide system of protective services to encourage independent living and to obviate protective placement wherever possible [s. 55.02, Stats.].

Protective services may be provided under any of the following circumstances, only the last of which involves a court proceeding:

1. A person needs, or believes he or she needs, these services and voluntarily seeks protective services;

2. A person needs services and an interested person requests the services on the needy person's behalf;

3. A guardian requests services and consents to services on behalf of a ward;

4. The DHSS determines to provide services on behalf of anyone in need of them; and

5. A court orders services for a person who has been found legally incompetent, if the court finds that person would otherwise incur a substantial risk of physical harm or deterioration. No statutory procedures are set forth for a protective services proceeding [s. 55.05 (2), Stats.].

F. EMERGENCY SERVICES

Protective services may be provided on an emergency basis for not more than 72 hours, without consent or a court order, when there is reason to believe that, without the services, the person receiving the services or other persons will incur a substantial risk of serious physical harm. A court proceeding need not be held in conjunction with the provision of emergency services unless forcible entry of the person's premises is required, in which case a court order enabling the entry is usually required [s. 55.05 (4), Stats.].

G. GUARDIANSHIP AND CONSERVATORSHIP

The purpose of court proceedings to establish a guardianship or a conservatorship is to grant one person the legal right to make certain decisions and to act on behalf of another person who, in the case of guardianship, is legally incompetent or, in the case of a conservatorship, believes he or she is unable to manage his or her own property.

1. Guardianship

a. Petition for Guardianship

Any person may petition a court for the appointment of a guardian over another person. There are several statutory grounds for seeking a guardianship; for purposes of this Brief, only guardianship based on incompetency will be discussed. As noted in Section C of this Part, a legal declaration of incompetency and the appointment of a guardian is a prerequisite to obtaining a protective placement under ch. 55.

A petition to appoint a guardian must allege that the person who is the subject of the proceedings is incompetent, as defined in Part I, C, of

this Brief. The allegation must be based on actual examination of the subject's mental condition. The subject must receive notice of the petition and must have a guardian ad litem appointed on his or her behalf. The subject must appear at the hearing and may request a jury trial, the appointment of full legal counsel and an independent medical or psychological examination [ss. 880.08 (1) and 880.33 (1) and (2), Stats.].

b. Appointment of Guardian

A court may find that the subject is competent or is incompetent in full or in part. In the case of a finding of limited incompetency, the court must make a specific finding as to which legal rights the subject is competent to exercise, such as the right to vote, marry, obtain a driver's license or other licensure, enter into contracts or testify in legal proceedings. A limited guardian is then appointed. Where the court finds full incompetency, a guardian with full guardianship powers is appointed. Either finding must be based on clear and convincing evidence of incompetency [s. 880.33 (3) and (4), Stats.].

A guardianship appointment endures throughout the life of the ward, unless a court terminates the appointment, limits the guardianship or appoints a new guardian. A guardianship of a ward who was declared incompetent when under the age of 18 must be reviewed when the ward reaches the age of majority [s. 880.34, Stats.].

c. Powers and Duties of Guardian

A guardian has the power to act on behalf of the ward in personal matters, but may not represent the ward's property interests unless appointed guardian of the ward's property by a court. A guardian may admit a ward to a group home, foster home or community-based residential facility, if the house or facility has fewer than 16 beds, or to a nursing home, temporarily, for respite care. The guardian may also make an emergency protective placement of the ward, as described in Section D of this Part, apply for and accept protective services on behalf of the ward or apply for the protective placement or involuntary commitment of the ward.

The guardian is required to make an annual report on the ward's condition to the court and to the county mental health agency. This report must include a statement of whether the ward is living in the least restrictive environment consistent with his or her needs [s. 880.38, Stats.].

A guardian may not consent to the transfer of a protectively-placed ward to an acute psychiatric unit for diagnosis or treatment. No such transfer may be made, without the ward's consent, unless an involuntary

commitment order has been issued by a court [State ex rel. Watts v. Combined Community Services Board of Milwaukee County, 122 Wis. 2d 65 (1985)].

2. Conservatorship

If a person believes he or she is unable to properly manage the person's own property or income, he or she may voluntarily apply to a court for the appointment of a conservator. A conservator may have the powers of a guardianship over the property of the person, but not over the person. No finding of competency or incompetency is implied by the appointment of a conservator. No one may apply for the appointment of a conservator over another person [s. 880.31, Stats.].

H. VOLUNTARY ADMISSION OF ADULTS TO TREATMENT FACILITIES

An adult may be voluntarily admitted to an approved inpatient treatment facility or to a state inpatient treatment facility if he or she is mentally ill and has the potential to benefit from inpatient care, treatment or therapy. An adult who is voluntarily admitted does not need to meet the standards of dangerousness which must be met for a person to be involuntarily committed. The treatment director of the facility or the director's designee and the director of the appropriate county mental health board must approve the admission [s. 51.10 (4), Stats.].

An adult may be voluntarily admitted in one of two ways. First, he or she may apply for admission in writing. If the person is an adult for whom a guardian has been appointed under ch. 880, Stats., because of the person's incompetency, voluntary admission may only occur with the consent of both the guardian and the ward.

Second, an adult may be admitted upon a request by a physician of the facility, signed before at least two witnesses. The request must state that the physician has advised the patient in the presence of the witnesses, both orally and in writing, of the right to leave the facility, the risks or treatment, the patient's right to the least restrictive form of treatment appropriate to the patient's needs and the responsibility of the facility to provide the patient with this treatment.

If the patient is admitted under the second method, a guardian ad litem for the patient must be appointed to visit the facility to determine if there is compliance with these requirements. If, within seven days after admission under the second method, the patient signs a voluntary admission application as provided under the first method, the patient, the guardian ad litem and the physician who signed the admission request must

appear before a court to determine whether the patient is to remain in the facility as a voluntary patient [s. 51.10 (4m) and (8), Stats.].

At the time of admission to an inpatient treatment facility, the person must be informed both orally and in writing of his or her right to leave upon submission of a written request to leave, except when the director of the facility or the director's designee files a statement of emergency detention. Writing materials for use in requesting discharge must be available to the person at all times [s. 51.10 (5), Stats.].

A person admitted to an inpatient treatment facility has the rights set forth under s. 51.61, Stats., enumerated in Part II, B, 1, of this Brief. Among these rights are the right to the least restrictive conditions necessary to achieve the purposes of admission, the right to receive prompt and adequate treatment, rehabilitation and educational services appropriate for his or her condition and the right to refuse all medications and treatment [s. 51.61 (1) (intro.), Stats.].

I. VOLUNTARY ADMISSION OF MINORS TO TREATMENT FACILITIES

The voluntary admission of minors to inpatient treatment facilities must be according to the following procedures if the admission is to a facility operated by or under contract with the DHSS or a county mental health board. [Admissions to other inpatient treatment facilities need not follow these procedures.]

1. Application for admission must be made by the minor's parent or guardian if the minor is under 14 years of age. Application must be made by the minor and the minor's parent or guardian if the minor is 14 years of age or older. A minor 14 years of age or older may be voluntarily admitted without parental consent if the juvenile court finds any parental objection to be unreasonable, if the parent cannot be found or if there is no parent with legal custody [s. 51.13 (1), Stats.].

2. Prior to admission, or as soon thereafter as possible, the minor and the parent or guardian must be notified of the following:

a. The juvenile court review procedure;

b. If the minor is 14 years of age or older, his or her rights to request discharge and to be discharged within 48 hours if no petition for emergency detention, emergency commitment, involuntary commitment or protective placement is filed;

c. If the minor is 14 years of age or older, his or her rights to consent to or refuse treatment; and

d. If the minor is under 14 years of age, his or her rights to a hearing to determine the continued appropriateness of the admission [s. 51.13 (3), Stats.].

3. The treatment director of the facility must file a petition for review of the admission with the juvenile court within three days of admission. The court must review the petition and the admission documents to determine if the admission is voluntary (if the minor is 14 years of age or older), whether the minor needs treatment, whether the facility is appropriate and whether the setting is no more restrictive than necessary. A hearing may be ordered by the juvenile court and must be ordered if the minor does not agree to admission or if requested by the minor, counsel for the minor, parent or guardian [s. 51.13 (4), Stats.].

The court need not review an application for short-term admission for diagnosis and evaluation or for dental, medical or psychiatric services if the admission will not exceed 12 days. If a minor 14 years of age or older is admitted on a short-term basis, the application must be: (a) signed by the minor's parent or guardian and by the minor; and (b) reviewed by the facility director [s. 51.13 (6), Stats.].

Regardless of whether a voluntary admission of a minor involves DHSS or a county mental health board, the minor has the rights set forth in s. 51.61, Stats.

J. VOLUNTARY ADMISSION TO PROTECTIVE PLACEMENT FACILITIES

Anyone who is legally and actually capable of consenting may voluntarily consent to enter a residential placement facility such as a group home, foster home, community-based residential facility or nursing home without a court-ordered protective placement. A person found incompetent by a court, or who is in fact incapable of understanding the alternatives, may not consent to admission to these types of facilities [s. 55.05 (5) (a), Stats.].

PART IV

COMMITMENTS ARISING OUT OF CRIMINAL PROCEEDINGS

This Part of the Brief describes criminal commitments, arising out of criminal proceedings where the defendant has been found incompetent to stand trial or not guilty by reason of mental disease or defect. Also described here are civil commitments of inmates of prisons.

A. INCOMPETENCY TO STAND TRIAL

1. Standard

Section 971.13 (1), Stats., provides: "No person who lacks substantial mental capacity to understand the proceedings or assist in his or her own defense may be tried, convicted or sentenced for the commission of an offense so long as the incapacity endures" (emphasis added). Thus, when competency of the defendant to stand trial is raised as an issue, the court must make a finding as to the defendant's competency before the trial may proceed. A finding that the defendant is not competent to stand trial usually results in the commitment of the defendant to a mental health facility.

A finding of "lack of competency to stand trial" is not equivalent to a finding of "incompetency" within the meaning of the protective placement or guardianship standards. Lack of competency to stand trial is related to the narrower purpose of assuring that the criminal defendant can effectively assist defense counsel at the criminal proceeding.

2. Procedure

The issue of competency to stand trial may be raised at any point in the criminal proceeding, including after a guilty verdict. Once the issue has been raised, the court must appoint at least one examiner to advise the court on the issue of competency. The examination may be done on an inpatient or an outpatient basis. During the examination period, the defendant may receive voluntary treatment and has the right to refuse treatment unless the treatment is necessary to prevent harm to the defendant or to others. The defendant may request an additional examiner of the defendant's choosing [s. 971.14 (2), Stats.].

As with civil incompetency proceedings under ch. 880, the person seeking to establish that the defendant is not competent has the burden of establishing lack of competency by clear and convincing evidence. The

court must either find the defendant competent, not competent and not likely to become competent within 18 months, or not competent but likely to become competent within 18 months [s. 971.14 (5), Stats.].

If the court finds the defendant competent to stand trial, the trial is resumed. If the court finds the defendant not competent, and not likely to become competent, the trial is suspended and the defendant released, if under detention. The defendant may be taken immediately into custody and civil commitment or protective placement proceedings commenced. If the defendant is found not competent, but likely to become competent, the defendant must be committed for the purpose of attaining competency to stand trial.

A criminal commitment based on a finding of lack of competency to stand trial may generally last up to 18 months, with periodic examinations during the commitment period. If, during this time, the defendant becomes competent, the criminal proceeding is resumed. If the court determines that it is unlikely that the defendant will become competent during the commitment period, it must release the defendant from the criminal commitment order. At this point, emergency detention may be instituted and a civil commitment proceeding commenced [s. 971.14 (5) and (6), Stats.].

If, during the criminal detention period, it appears that treatment is appropriate, the court may order continued treatment, including the use of psychotropic drugs, to achieve competency of the defendant for the purpose of attaining competency and continuing the criminal proceeding [s. 971.14 (5) (d), Stats.].

B. NOT GUILTY BY REASON OF MENTAL DISEASE OR DEFECT

1. Standard

A criminal defendant may not be held responsible for criminal conduct if the defendant lacked substantial capacity either to appreciate the wrongfulness of his or her conduct or to conform his conduct to the requirements of law at the time of the conduct alleged to be criminal. A mental disease or defect must be more than criminal or antisocial behavior. Upon a finding of not guilty by mental disease or defect, the defendant must be acquitted of the criminal charge [s. 971.15, Stats.].

2. Procedure

When a defendant raises a defense of not guilty by mental disease or defect, the criminal proceeding must be divided into two or three phases.

First, a proceeding must be held to determine whether the defendant committed the criminal offense (the "guilt" phase). A subsequent proceeding must be held to determine whether the defendant suffered a mental disease or defect at the time of the offense, if found guilty (the "insanity" phase). If the defendant is found to have a mental disease or defect, the court must automatically commit the defendant. Subsequently, a third proceeding may be requested to determine whether the defendant continues to be mentally ill and dangerous under the commitment standards (the "commitment" phase).

If the defendant is found guilty of committing the offense and has raised the insanity defense, the court must appoint at least one, buy not more than three, physicians to examine the defendant and to report to the court. The defendant may also be examined by a physician or other expert of his or her own choosing. Neither the state nor the defendant may call an examiner to testify at the insanity phase of the trial unless that examiner's report is disclosed to the opposing side three days before trial [s. 971.16, Stats.].

If, after the insanity phase, the court or a jury finds the defendant not guilty by reason of mental disease or defect, the court must automatically order the person committed. If the defendant petitions the court for a reexamination of the defendant's mental condition, the court must hold a hearing to determine whether the person is presently mentally ill and dangerous under the commitment standards. The underlying criminal act may be used as the basis for a finding of dangerousness. If the defendant meets the commitment standards, the commitment may be continued for the maximum period for which the defendant could have been imprisoned had the defendant been convicted for the underlying offense. After this period, the person must be discharged, at which time a petition for civil commitment may be filed by the DHSS [s. 971.17, Stats.; see, also, State v. Field, 118 Wis. 2d 269 (1984), declaring the automatic criminal commitment provision constitutional].

C. CIVIL COMMITMENT OF A PRISON INMATE

Generally, a mental health commitment of a prison inmate proceeds under the involuntary civil commitment provisions described in Part III, A, of this Brief. A separate commitment standard may be used, however. Rather than finding that the inmate is dangerous under one of the four standards for civil commitment, the court may commit an inmate based on a

finding that he or she is in need of treatment and that the appropriate, less restrictive forms of treatment have been attempted and have been unsuccessful. This standard for commitment of inmates may not be used after July 1, 1987 [s. 51.20 (1) (ar), Stats.].

If these standards are met, a court must commit the inmate to the DHSS for placement in a state mental health inpatient facility or to an outpatient treatment program in the prison. The outpatient treatment may be provided on a conditional basis, subject to transfer to an inpatient facility if the treatment conditions are not met.

If the inmate was committed under one of the involuntary commitment dangerousness standards, the inmate's commitment may not continue beyond the inmate's date of release from prison and is, in addition, subject to the six-month and one-year limitations for involuntary commitments. If the inmate was committed under the alternative "need for treatment" standard, the total commitment period may not continue longer than 180 days in any 365-day period [s. 51.20 (13) (g), Stats.].

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